Interventions and Best Practices to Eliminate Stigma and Discrimination in PEPFAR Programs: Results From a Programmatic Assessment

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Empowering Health
Columbia University
Mailman School
of Public Health

Collaborators

- **U.S. Centers for Disease Control and Prevention (CDC)**
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- **Department of Defense (DoD)**
  - Vienna Nightingale
- **Health Resources and Services Administration (HRSA)**
  - Myat Htoo Razak and Tracey Gantt
- **Peace Corps (PC)**
  - Hannah Gardi
- **U.S. Agency for International Development (USAID)**
  - Kent Klindera

The findings and conclusions in this presentation are those of the presenters and do not necessarily represent the official position of the funding agency.

Background

- **Stigma and discrimination (SD) against people living with HIV and those at high risk of acquiring HIV (i.e. key and priority populations) remain major barriers to accessing HIV services**

- **Elimination of SD in programs supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is essential to achieve epidemic control**

- **Activities, practices, and interventions used to eliminate SD in PEPFAR-supported programs have previously not been well documented**

- **A PEPFAR SD Task Force identified the need for an assessment of all SD-related programmatic activities funded by U.S. Government (USG) agencies**

Methodology

- **An online Programmatic Assessment survey was developed with engagement of points of contact from five PEPFAR-funded USG agencies**
  - CDC, DoD, HRSA, PC and USAID

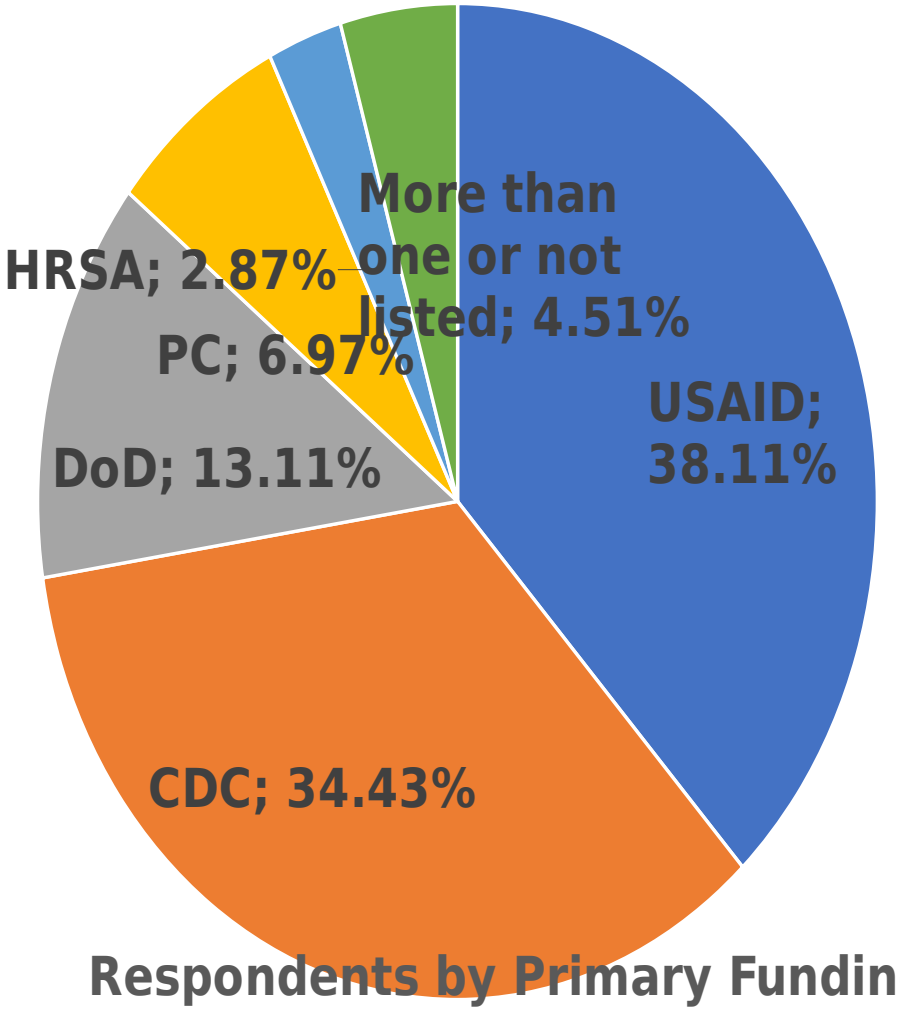
- **The assessment collected information about direct SD programs and activities, as well as topics related to SD such as patients' rights, confidentiality and infection control practices**

- **An email list was created of implementing partner (IP) organizations and PC posts who had received PEPFAR funding since December, 2014 (PEPFAR 3.0)**

- **Contacts on the list were emailed by ICAP and asked to assign someone on their team to complete the Programmatic Assessment from December 2018 to March 2019**

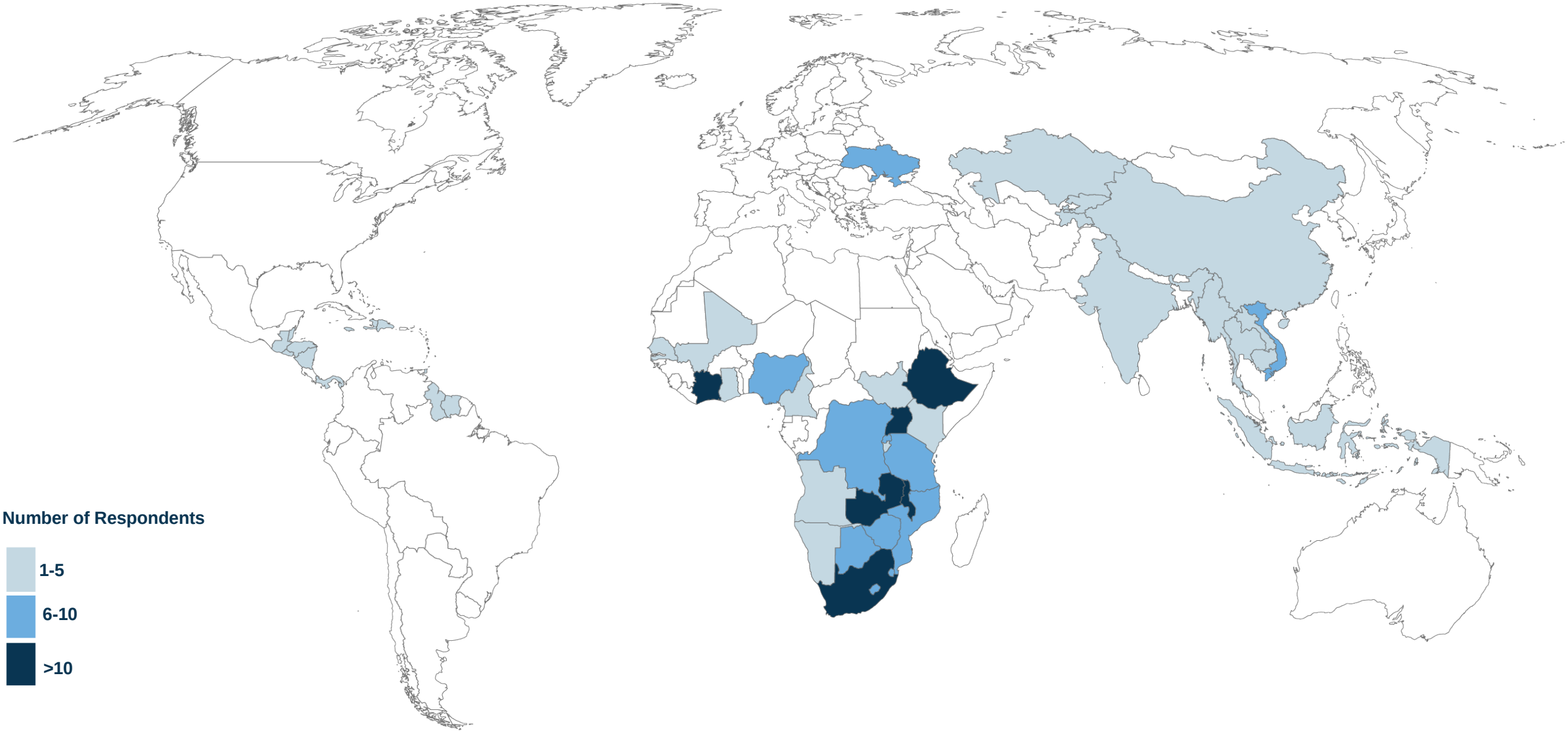
Response

- **Total number of IP/PC post contacts emailed: 413**
- **Number of currently active contacts: 340 (82%)**
  - Among active contacts 267 (79%) were CDC or USAID implementers
- **Number of responses from IPs/PC posts: 244**
- **Number of countries represented: 50**



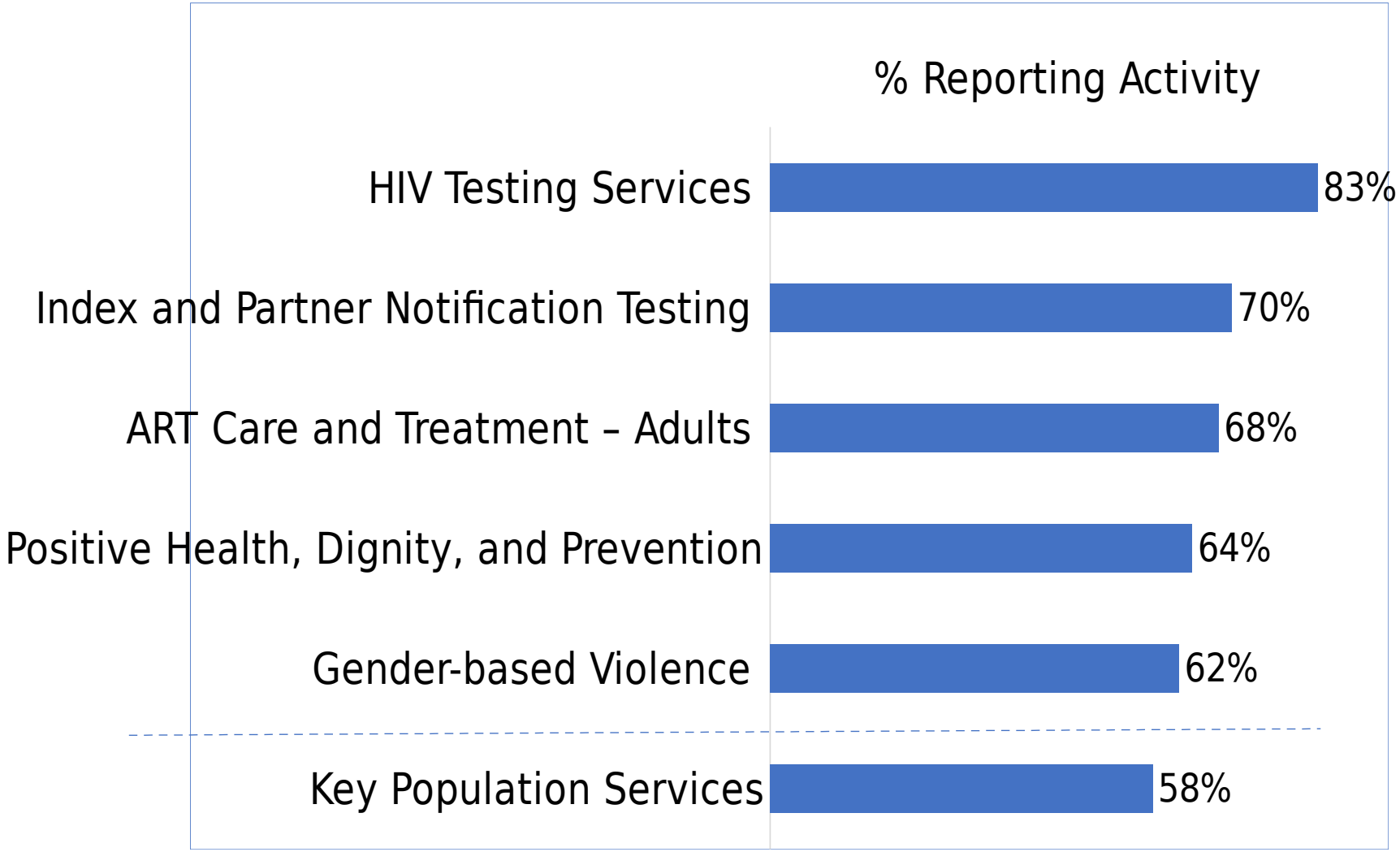
Respondents by Primary Funding Source

Respondents’ Geographic Distribution



Program Characteristics

- Worked in HIV for median of 13 years (IQR 8-17)
- Settings:
  - 66% health facility-based activities
  - 68% community-based activities
- Supporting:
  - 99,077 lay workers
  - 73,749 clinical professionals
  - 44,213 other support staff



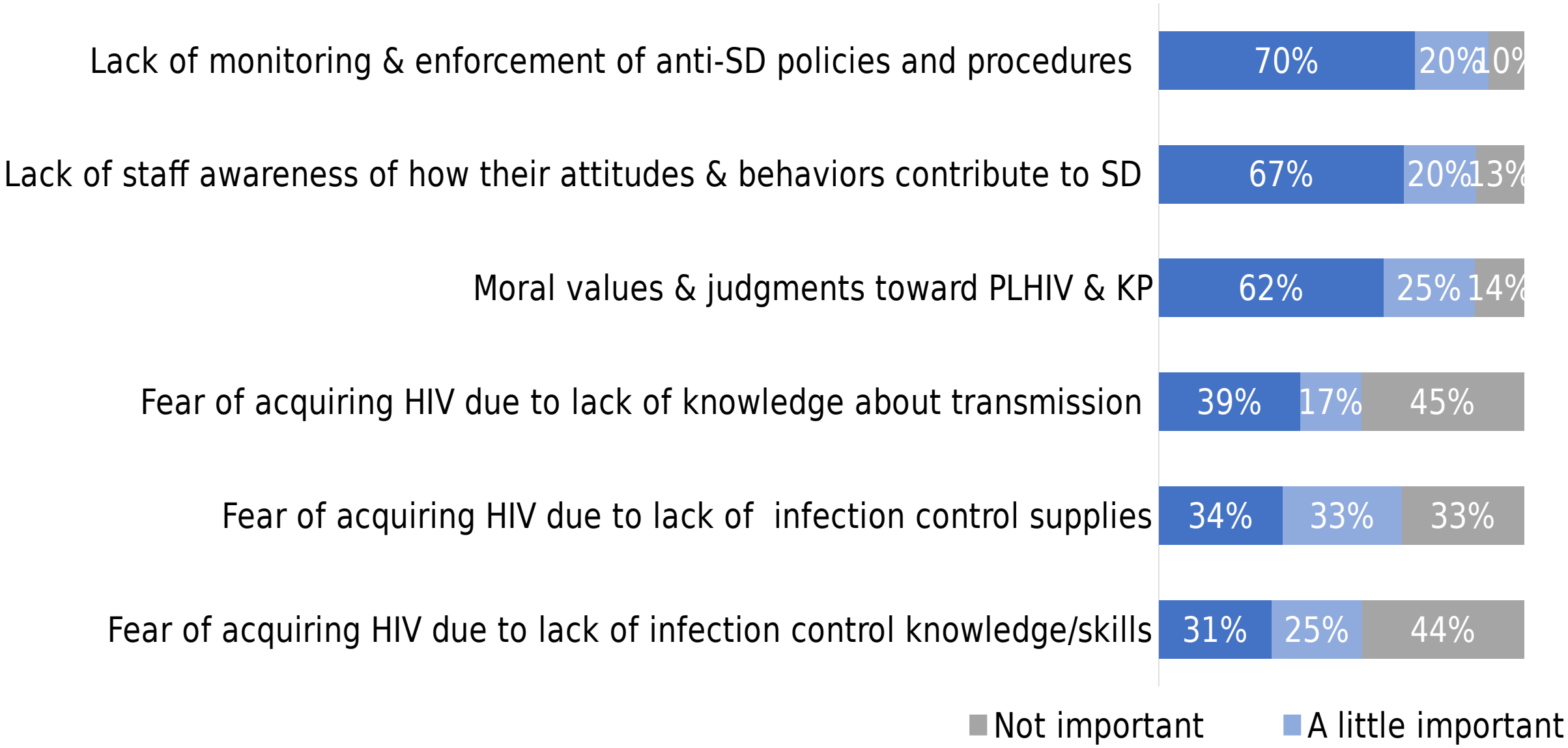
Experience Related to SD in Healthcare Settings

- **The majority of IP/PC post respondents saw SD as a barrier to accessing HIV care at primary healthcare facilities (78%) and in community settings (58%)**

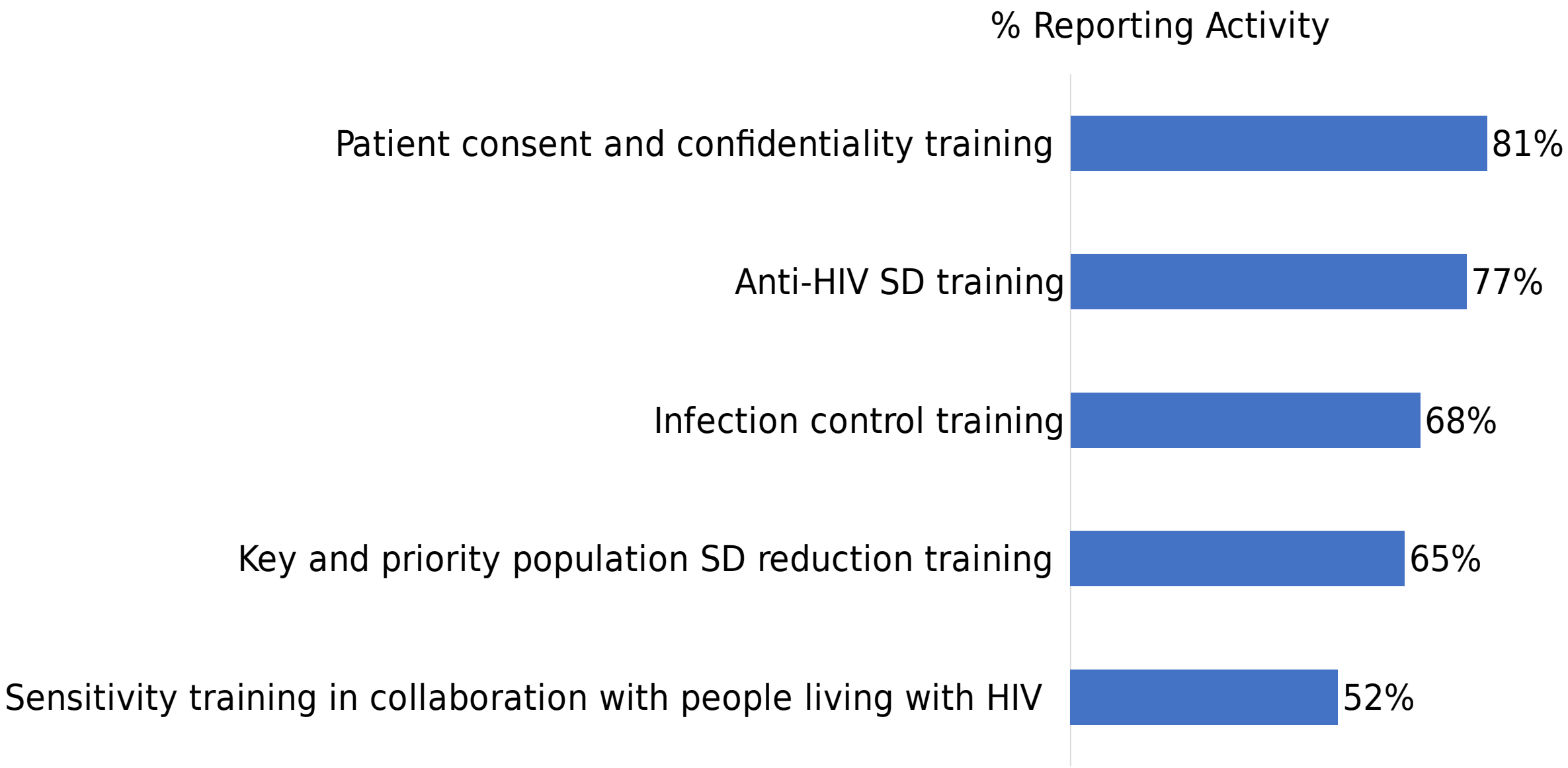
- **SD behavior had been witnessed by IP/PC post respondents across all cadres of health facility staff**
  - 29% among clinical professionals
  - 26% among administrative support staff
  - 20% among lay workers

- **Of those with access to information on patient complaints (~54 IP organizations), the most commonly reported:**
  - Non-confidential care
  - Differential treatment
  - Disrespectful or non-dignified care
  - Refusing to provide treatment or referring clients unnecessarily to other staff or facilities
  - Abandonment of care, such as failure to monitor and intervene when needed

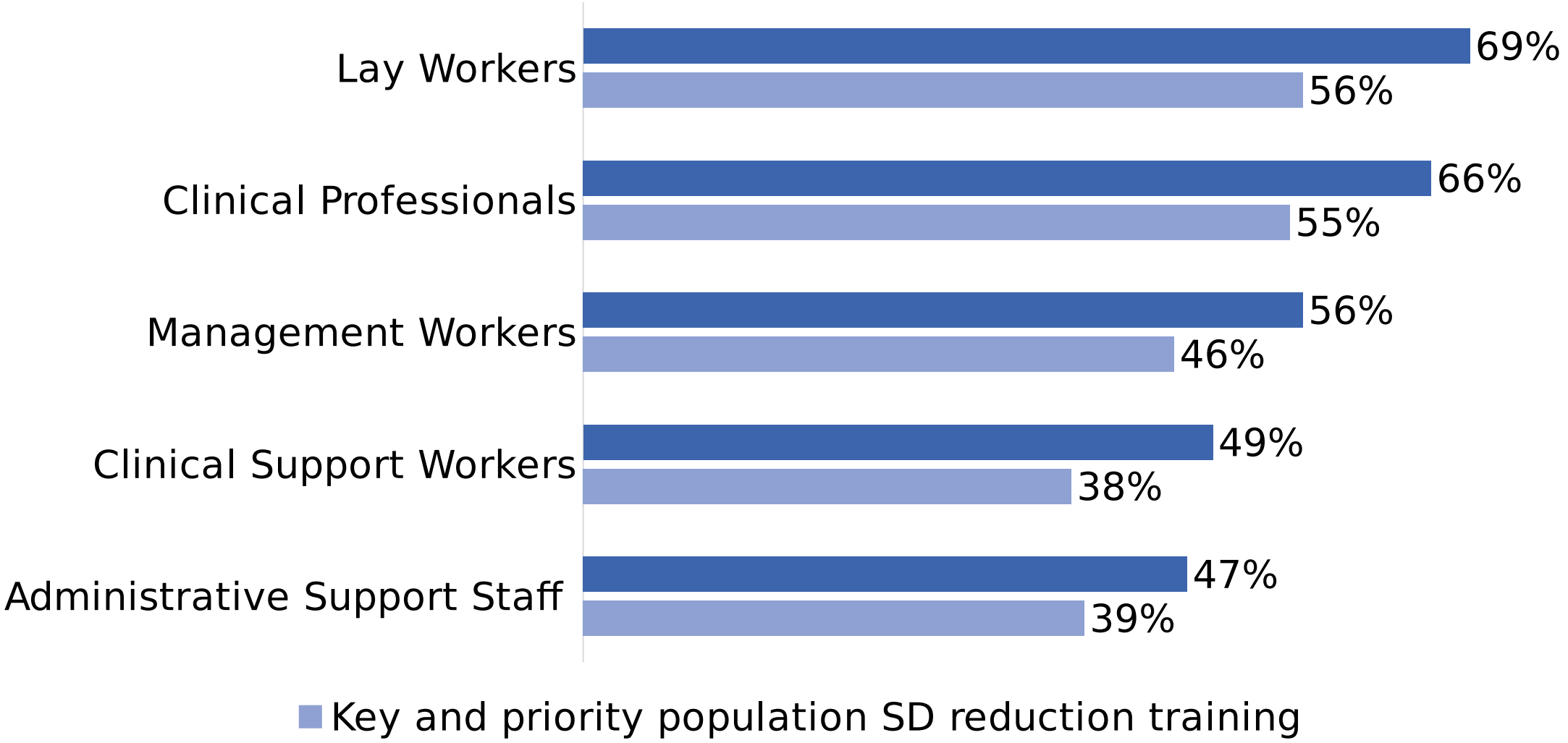
Reported Reasons for SD in Healthcare Settings



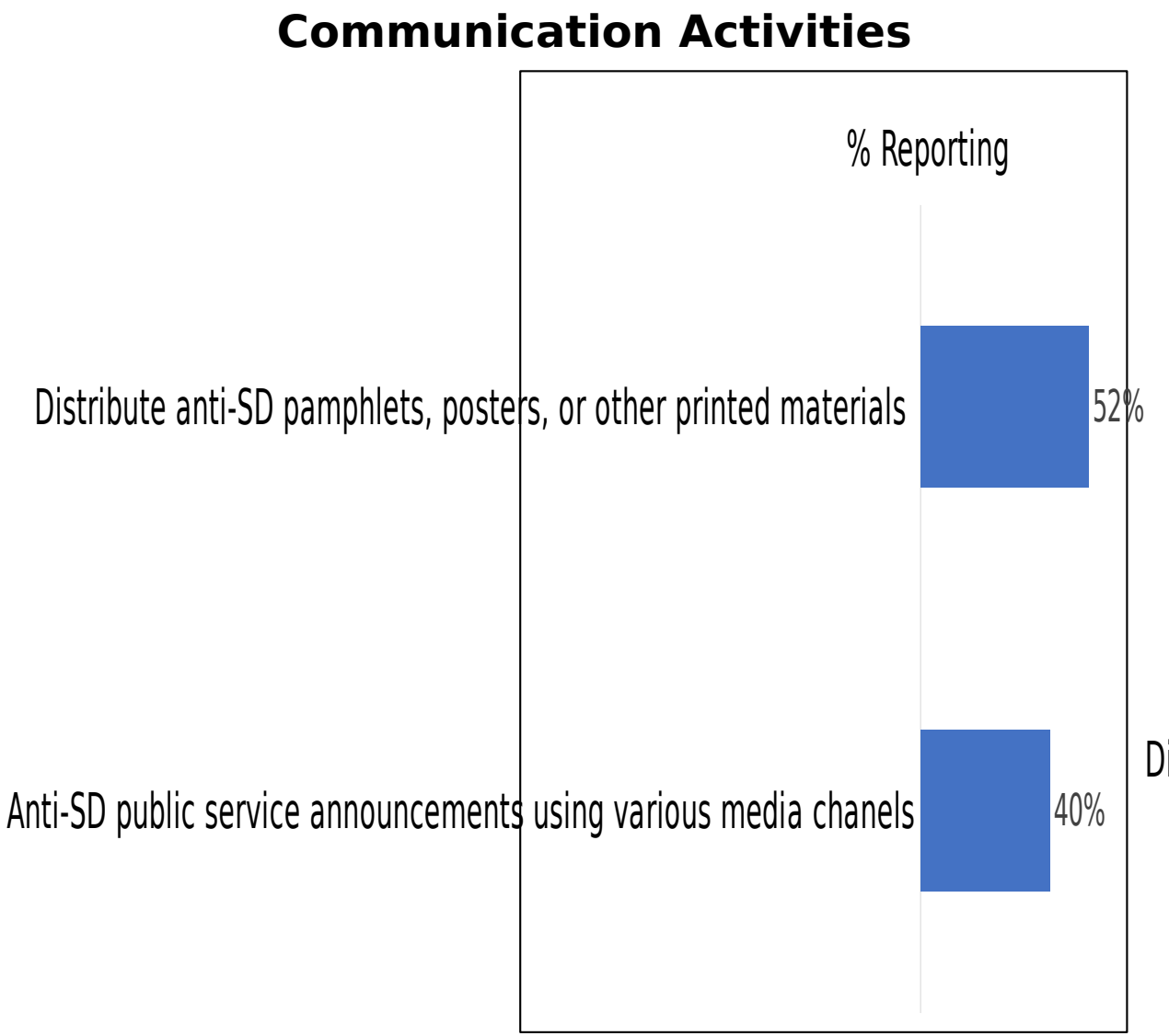
Support for Training Activities

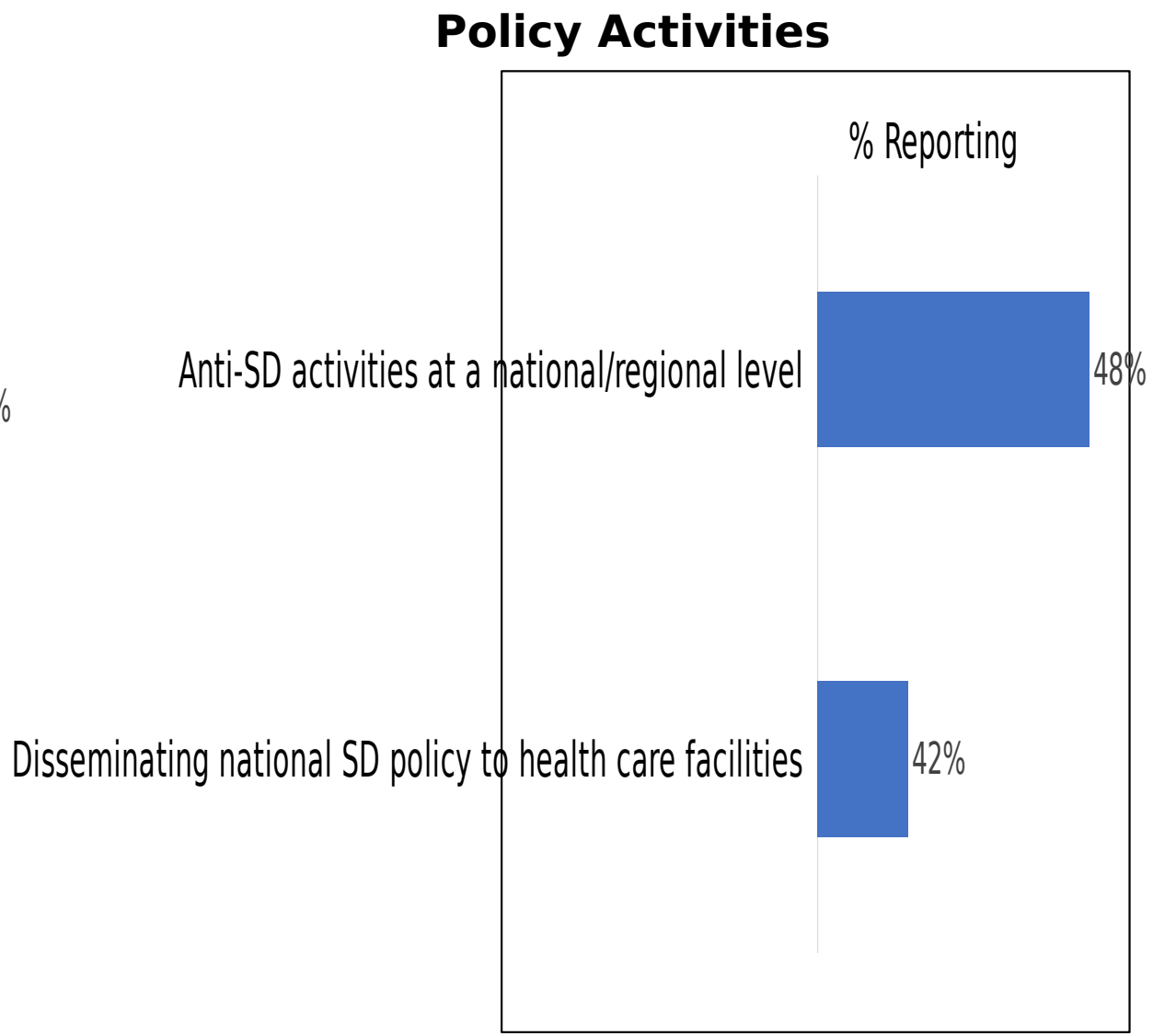


Training by Cadre

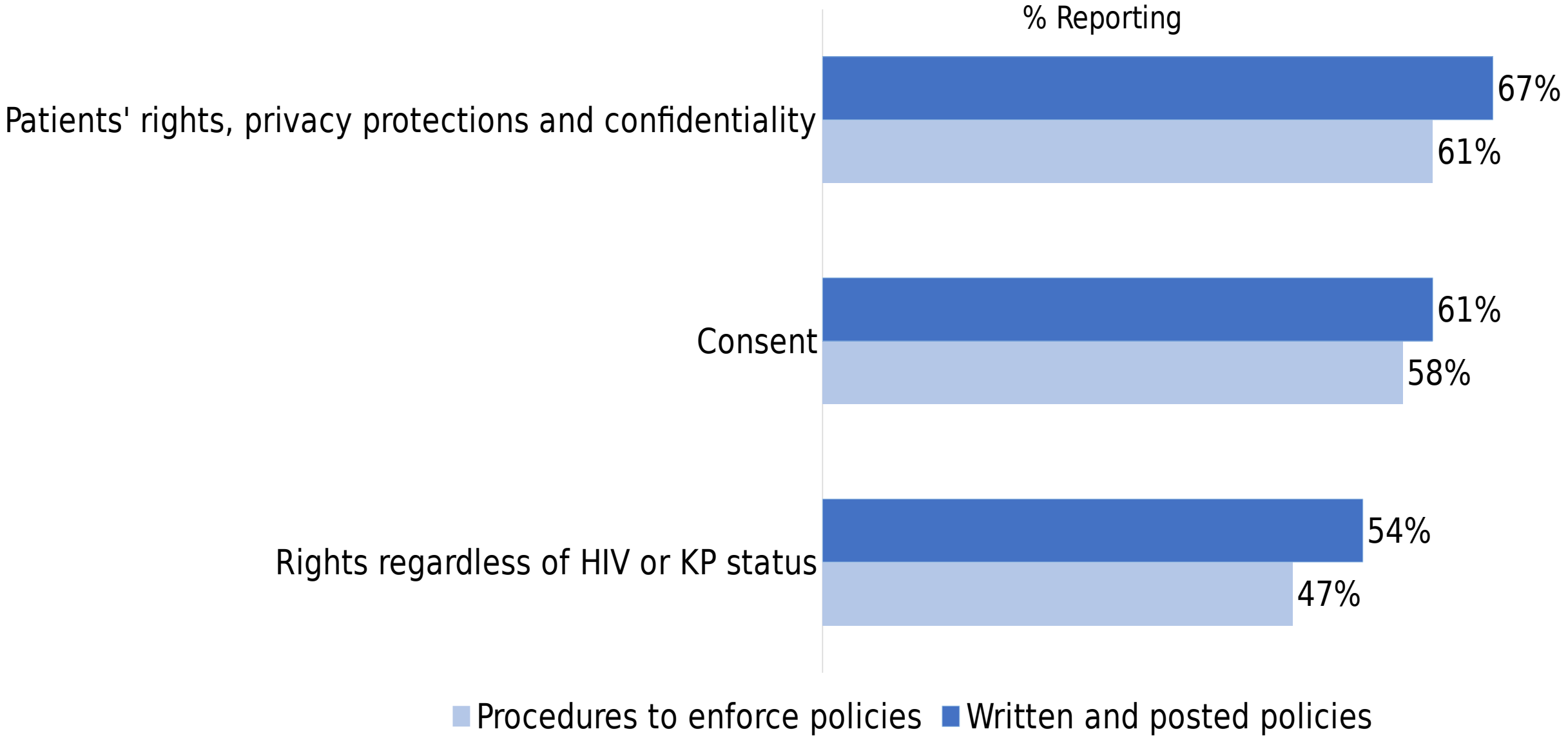


Support for Communication and Policy Activities

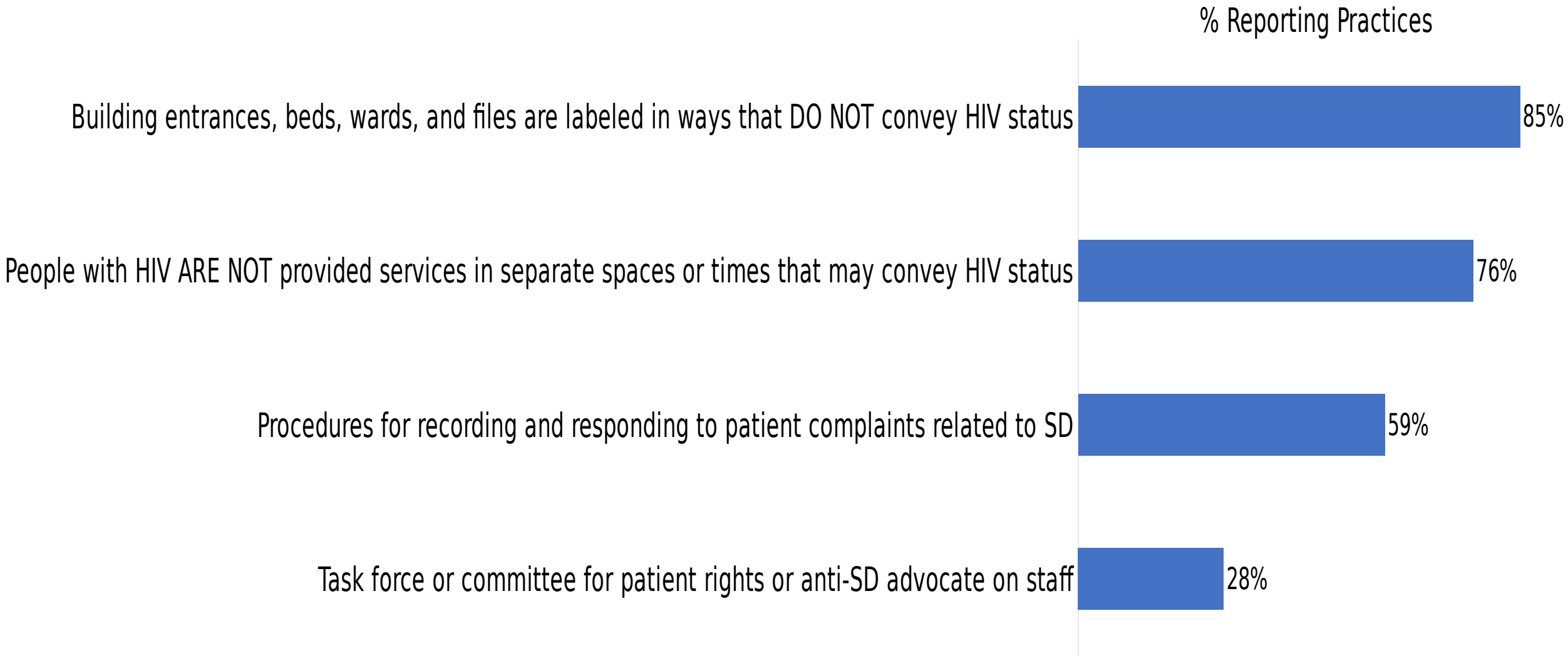




Patient Rights Policies and Procedures at Entities Supported

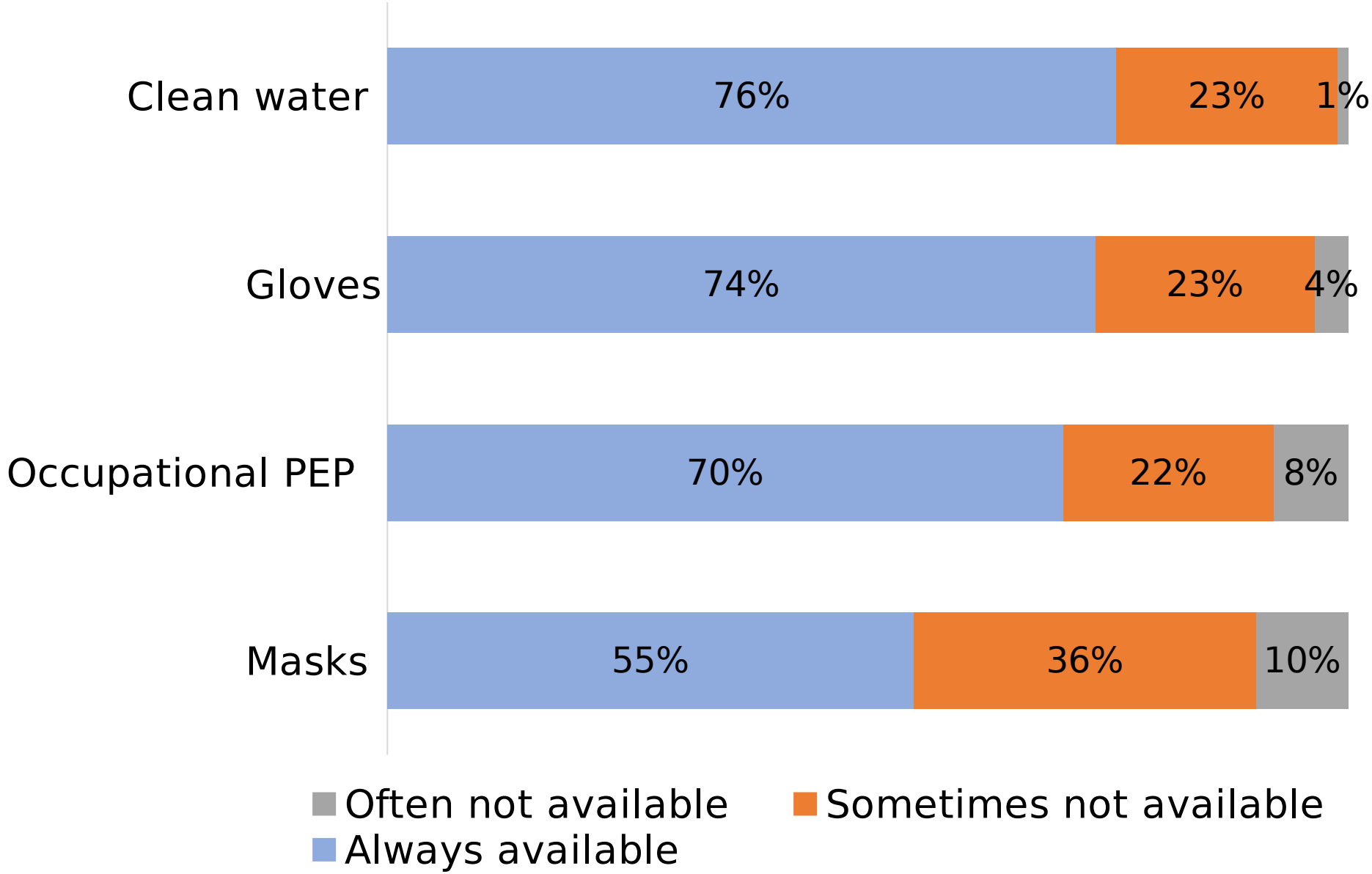


Structural Practices at Entities Supported



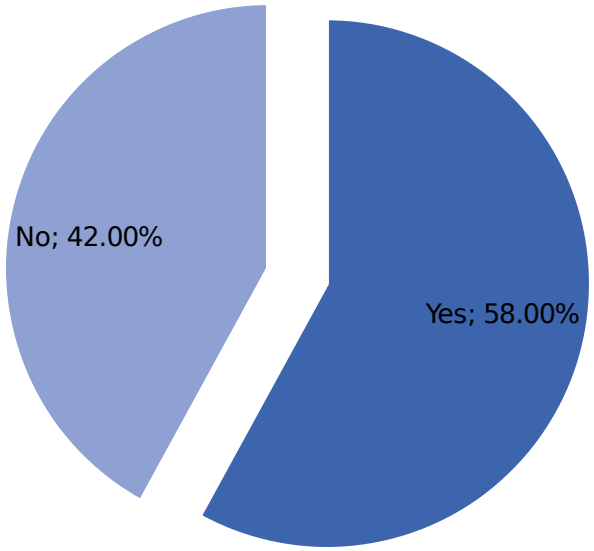
Infection Control Supplies at Entities Supported

62% of IP/PC post respondents considered fear of acquiring HIV due to lack of essential supplies for infection control an important reason for SD



Awareness of Intervention Effectiveness

Aware of Evidence of Effectiveness



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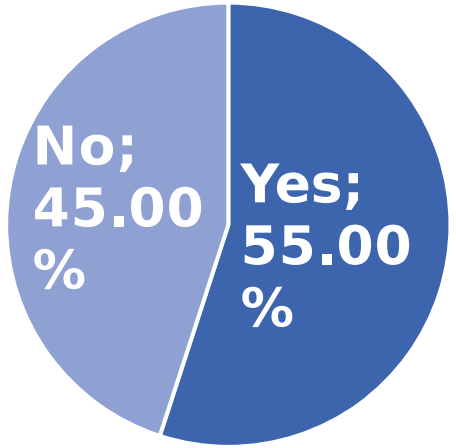
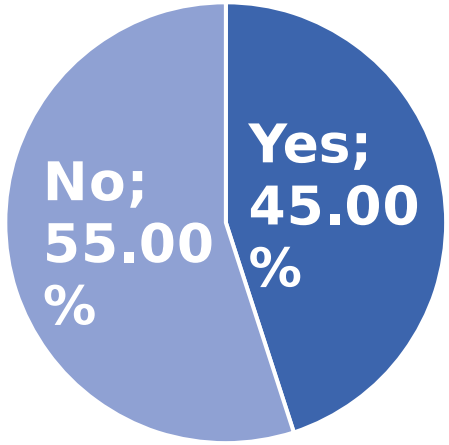
Any Formal Evaluation



Observational Evidence Only



Lessons Learned

- **Training**
  - Fewer IPs/PC posts reported sensitivity training for key and priority population groups than for HIV
  - Only 1 in 2 IPs/PC posts reported sensitivity training that involved people living with HIV
  - Variation in training by cadre, with less training provided for clinical and administrative support staff

- **Policies and procedures**
  - Limited availability of written and posted policies regarding patient rights and accompanying enforcement procedures
  - Gaps in redress processes and advocates for those experiencing SD

- **Healthcare settings**
  - Almost 1 in 4 IPs/PC posts reported practices that could disclose the HIV status of patients
  - Gaps in consistent availability of essential infection control commodities

- **Evidence of effectiveness**
  - Only 1 in 3 IPs/PC posts reported a formal evaluation and 42% unaware of evidence to support interventions

Conclusions

- **Almost all respondents directly support activities that address HIV-related SD**

- **Wide variety of anti-SD interventions included: trainings, broad communications and national policy activities, patients' rights policies and procedures, and infection control practices**

- **Opportunities exist for improvement in a number of domains that could contribute to further SD reduction:**
  - Broader and diversified training of staff
  - Development and enforcement of protective policies
  - Redress of SD complaints and patient rights advocacy
  - Support healthcare settings to provide a SD-free environment (e.g. supplies, privacy protection)

- **Future work needed to conduct formal evaluations to better enable identification and scale-up of best practices**

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Questions or comments:
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Thank You

Photo: UNAIDS

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